TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-17-2918-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
June 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/10/2016 I performed an evaluation to determine maximum medical improvement and impairment of the above named claimant. I performed this examination at the request of the injured employee and the treating doctor."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office found that Dr. Weeks performed a MMI/IR exam of the injured worker on 9/18/2015 where he placed her at MMI and gave her a 10% impairment rating. A Designated Doctor exam was then performed by Dr. Pfell on 1/13/2016 where he placed the injured employee at MMI with a 7% impairment rating."

Response Submitted by: State Office of Risk Managment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2016	Examination to Determine Maximum Medical Improvement & Impairment Rating	$950.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Processed based on multiple or concurrent procedure rules.
   - W3 – Additional payment made on appeal/reconsideration.

- 5080 – Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).

Issues

Is State Office of Risk Management's reason for denial of payment supported?

Findings

Trenton D. Weeks, D.C. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating referred by the treating doctor, performed on June 10, 2016. State Office of Risk Management (SORM) denied the disputed services with claim adjustment reason code 59 – "PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES."

SORM stated in its response that "Dr. Weeks performed a MMI/IR exam of the injured worker on 9/18/2015 where he placed her at MMI and gave her a 10% impairment rating. A Designated Doctor exam was then performed by Dr. Pfell on 1/13/2016 where he placed the injured employee at MMI with a 7% impairment rating." Texas Labor Code §408.0041(f-2) states:

> An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:
> (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and
> (2) the employee is not satisfied with the designated doctor's opinion.

Review of the available information finds that the designated doctor's opinion was not the employee's first evaluation of maximum medical improvement and impairment rating. Therefore, SORM's denial of payment is supported. No reimbursement is recommended for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	July 11, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.